Louisiana Medicaid
Dichlorphenamide (Keveyis®)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for dichlorphenamide (Keveyis®).

Additional Point-of-Sale edits may apply.

Approval Criteria

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has **ONE** of the following diagnoses:
    - Primary hypokalemic periodic paralysis; **OR**
    - Primary hyperkalemic periodic paralysis; **OR**
    - Paralysis in related variants (including, but not limited to, Paramyotonia Congenita with periodic paralysis or Andersen-Tawil syndrome); **AND**
- Dichlorphenamide (Keveyis®) is prescribed by, or the request states that this medication is being prescribed in consultation with, a neurologist; **AND**
- By submitting the authorization request, the prescriber attests to the following:
    - Other potential causes of muscle weakness have been ruled out; **AND**
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
    - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
    - The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not receive the requested medication in combination with any medication that is contraindicated or not recommended per FDA labeling.

Duration of initial authorization approval: 2 months*

*The response to Keveyis® may vary. Therefore, prescribers should evaluate the patient's response after 2 months of treatment to decide whether Keveyis® should be continued.

Reauthorization Criteria

- The recipient continues to meet initial approval criteria; **AND**
- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of reauthorization approval: 6 months

References

Keveyis® (dichlorphenamide) [package insert] Haifa Bay, Israel; Taro Pharmaceutical Industries Ltd; November 2019. https://www.keveyis.com/wp-content/uploads/keveyis-prescribing-information.pdf

Statland, Jeffrey M et al. "Review of the Diagnosis and Treatment of Periodic Paralysis." Muscle & nerve vol. 57, 4 (2018): 522-530. doi:10.1002/mus.26009

Weber F, Lehmann-Horn F. Hypokalemic Periodic Paralysis. 2002 Apr 30 [Updated 2018 Jul 26]. In: Adam MP, Ardinger HH, Pagon RA, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2020. Available from: https://www.ncbi.nlm.nih.gov/books/NBK1338/https://www.ncbi.nlm.nih.gov/books/NBK1338/

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